Mortality Review – Valerie Young
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Present
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Dr. N. Mirza, BDC Physician
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Dr. S. Palaganas, BDC Physician
Dr. V. Sharobeem, BDC Physician
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Dr. J. Hahn, BDC Psychiatrist
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Valerie Young was a 49 year old African American woman of the Protestant faith who functioned at the profound level of mental retardation. Prior to her death Ms. Young resided in unit 3-1 at BDC where she lived since her admission on September 26, 1990. Her mother, Viola Young was her correspondent. Valerie's family was very concerned and involved in her care.

Valerie was the second of three siblings born to her parents Viola and Sidney Young. There is no other history of MR in the family. Prior to her admission to BDC Valerie lived at home with her family. Valerie was the product of a normal pregnancy and delivery. Her mother noted developmental delays as Valerie had no speech by age two and was not toilet trained until she was 4½ years old. At the age of 13 she developed seizures. While she lived with her parents Valerie attended program at AHRC until age 21 and then at YAI until her admission to BDC.

Valerie was alert and aware of her environment. She was able to follow simple directions and recognized people she was familiar with. She was able to communicate with short 1 to 4 word phrases and gestures. She had a very low frustration tolerance and was on behavioral interventions for aggression, disruption and non-compliance. She required supervision and assistance with all of her ADL's.

Prior to her death Valerie was diagnosed with the following:

- Profound Mental Retardation
- Schizoaffective Disorder
- Seizure Disorder
- Tardive Diskinesia
- Constipation
- Melanosis coli
- Brachial plexus neuropathy
- Peroneal neuropathy

Her medications while at BDC were:

- Inderal 80mg TID
- Klonopin 0.5mg HS
- Topomax 100mg BID
- Prevacid 15mg HS
- Vitamin B Complex 1 Tab OD
- Fleet enema three times per week
- Remeron 45mg HS
- Zyprexa 5mg AM & 20mg HS
- Tegretol 400mg AM, PM and HS
- Colace 200mg HS
- Metamucil 2 tsp HS

Valerie's medical history indicates that she had a lymph node biopsy in November, 2000 with negative results. She also had a hemoroidectomy in 1998. In 2002 she had a fracture of the right index finger. Additionally, in 8/01 she had a venous duplex and echocardiogram which were both normal. Valerie had a chronic history of psychiatric decompensations and hospitalizations. On 8/10/04 she was hospitalized for aggressive and agitated behavior. She was discharged on 8/23/04 on Clozaril, Tegretol, Topomax, Inderal and Remeron. On 12/1/04 she was again hospitalized because of agitation and aggressive behavior. She was discharged on 12/23/04 at which time the Clozaril was replaced with Zyprexa. Following this she was relatively stable on her medication regime. Klonopin was added to her medications as a sleep aide on 1/12/05. Her constipation problems were managed with bulk laxatives and fleet enemas.

Valerie had a chronic gait problem manifested by a high steppage gait on the right and dragging of the left foot. In March 2005 the left foot drop became prominent. She was seen by the neurologist on 4/7/05 at which time residual brachial plexopathy on the right and left foot drop and high steppage gait on the right was noted. Vitamin B complex was given, Valerie was referred to PT and an EMG/nerve conduction study was advised. On 4/26/05 she was seen by the neurologist and Peroneal Mononeuropathy – foot drop- was diagnosed. X-ray of the LS spine was advised and the EMG with nerve conduction to be done in a hospital setting under sedation because of needed level of pain tolerance and cooperation. The x-ray of the LS spine showed degenerative changes of L5-S1 and no fracture or dislocation. Valerie was seen by PT and scheduled for PT twice weekly. She was also seen by the orthodist for fabrication of a left ankle foot orthosis. The EMG under sedation was scheduled for 6/30/05 at Downstate Medical Center.

Valerie had several falls attributed to her gait problem, sedation from medication and her behavior. On 4/15/05 she fell during her shower and sustained a laceration on her left upper eye lid. As a consequence, her Zyprexa was reduced. On 5/20/05 she fell and sustained a laceration of the posterior scalp. At this point a wheelchair was introduced for times when Valerie was unsteady on her feet and a protective helmet was issued to prevent further injuries.

On 5/27/05 bilateral pitting edema of Valerie's feet was noted. Homan's test was performed and no reaction was noted. Positional venostatis was assumed and it was managed with leg elevation during rest periods. Valerie was also receiving physical therapy and was ambulating in both the residential and program areas. Valerie was subsequently observed complying with leg elevations.

On 6/19/05 at approximately 8:30 PM Valerie collapsed as staff were escorting her to shower following an enema. Despite resuscitative efforts by medical staff, EMS and ER staff at Brookdale Hospital she expired. An autopsy was done and found that the cause of death was a massive pulmonary embolism.

Conclusions

The Mortality Review Committee members discussed this case and noted that Valerie's medication regimen appeared appropriate and would not have predisposed her to a pulmonary embolism. The issue of Valerie's history of mild pitting edema was also discussed and it was noted that in the past diagnostic testing had not revealed reasons for concern. The most recent episode of edema was reviewed and Dr. Milos noted that

bilateral pitting edema, which she had, is an unlikely sign for DVT. He also noted that he had preformed the Homan's test to check for calf pain (potential sign of DVT), with negative results.

It was noted that Valerie was ambulatory but using a wheelchair for transport because of foot drop and gait instability. It was discussed that staff who monitored her may not have encouraged her to walk around because of fear of her falling. Members discussed possible preventative measures for consumers who are at a high risk for DVT's (i.e. smokers, sedentary, non ambulatory). The use of anti coagulants was discussed but was ruled out as a preventative measure because of the high risk of bleeding, particularly in consumers who are prone to falling. Members discussed that for those consumers who are able to walk, staff should be walking with them throughout the day. For consumers who are non ambulatory, elastic stockings or pressure boots could be used as needed or tolerated by the consumer.

Recommendations

1. For sedentary consumers who are ambulatory, or where otherwise indicated, physicians will include orders for staff to walk with the consumers periodically during the day.
2. For non-ambulatory consumers, physicians will consider the use of elastic stockings or pressure boots where tolerated.

Submitted by: _____
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